

Name: _____
Appointment Day: _____
Appointment Date: _____ Time: _____

OFFICE USE: Confirm correct patient? Yes/No _____	Seen By: _____	Time: _____
Time patient last ate: _____	last drank: _____	Bowel Prep: Complete/Incomplete _____

Pre-Admission Health Assessment – to be completed by Patient (Write answers or N/A if Not Applicable.)

Who is taking you home? Relationship to you: _____ *Walking, unescorted in taxi & public transport not allowed*

I have read and understood the preparation instructions, risks and safety of procedures, and had an opportunity to ask any questions I may have.

Name: _____ Sign: _____ Date: _____

What procedure are you having: _____	Age: _____	OFFICE USE ONLY:	
Reason for this test: (e.g. symptoms, family history, previous polyps etc)		Clinical indications:	
Previous surgery and year of surgery:		Past surgical history:	
Significant medical problems:		Past medical history:	
Relevant family history First degree relative cancers: _____ If yes, specify: _____ First degree relative early heart disease (under 65yo): _____		Relevant family history:	
MEDICATIONS YOU TAKE: You must list all prescribed, over-the-counter and complementary medications that you are taking.		Medication history:	
Name of medication	No. of tablets		
	Freq. per day		
	Reason for medication		
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Has there been any change to your medicines in last 3 months? If yes, what has changed? _____			
ALLERGIES – Do you have allergies to any of these?		Allergy history:	
Eggs	Soya		Medications
Tapes	Hay fever		Chlorhexidine Disinfectant
		Anaesthetic agents	
		Latex	
If any allergies, please provide name of medication & describe the reaction you get:			If significant allergy, staff change to red ID band

Intake

Smoking	If yes, how much? _____	per day	Recreational drugs	If yes, specify: _____
Alcohol	If yes, how much? _____	of times per	Relevant consumption history: _____	

Name: _____

To be completed by Patient (as best as you can) – please tick yes or no to the following:

CARDIOVASCULAR – Heart Issues	Yes	No	RESPIRATORY – Lungs or Breathing	Yes	No
Shortness of breath at rest/lying flat/mild exertion			Hay fever, sinus problems		
High blood pressure			Asthma		
Chest tightness, chest pains, angina, heart attack, heart disease			Chronic bronchitis, emphysema, chronic Airway disease, bronchiectasis		
Rheumatic fever, heart murmur			Moderate-heavy snoring		
Irregular pulse, palpitations, arrhythmia			Obstructive sleep apnoea		
Ankle swelling			CPAP, BiPAP at night, Home oxygen		
Pacemaker, artificial heart valve, Implanted devices			Gastrointestinal: Hiatus Hernia, Reflux, Gastric ulcers,		
METABOLIC/ENDOCRINE			TEETH, SKIN, MUSCULOSKELETAL		
Could you be pregnant now?			Any skin conditions, broken skin, wounds		
Contraceptive pill (oral contraceptive may not be effective during the bowel preparation)			Pressure areas, reddened skin due to friction/rubbing/pressure		
Breastfeeding			Loose teeth, chipped teeth		
Liver conditions, fatty liver, jaundice, hepatitis, cirrhosis			Caps, crowns, veneers, dentures, bridge, implant, other dental works		
Diabetes? Diet/Medications/Insulin (pls circle)			Neck trouble? A bit / Some / A lot		
Kidney conditions, kidney impairment			Jaw trouble? E.g. Pain, click, locking		
Lap band surgery, gastric banding surgery?			BLEEDING/CLOTTING		
NEUROLOGICAL, MENTAL HEALTH, SEDATION			Blood thinning medications? Anti-platelet medications? Bleeding tendency? Any of: Clopidogrel / Plavix / Iscover / Apixaban / Dabigatran / Rivaroxaban, Prasugrel & Ticagrelor / Warfarin, Coumadin?		
Past sedation or anaesthetic difficulties			Deep venous thrombosis DVT, Pulmonary embolism i.e. Blood clots in legs or lungs		
Post-anaesthetic confusion / delirium			Have you brought an *Advance Care Directive* (living will) with you?		
History of mental illness, e.g., depression, anxiety, psychosis			INFECTIONS		
Faints, funny turns, dizzy spells			Past 12 months, any admission (overnight or more) to any overseas healthcare facility		
Memory issues, dementia			Past 12 months, any CRE infections or contact with any patient with CRE		
Intellectual disability			Are you currently being treated for any infections? Ever had TB/Tuberculosis?		
Fits, epilepsy, TIA, strokes, Parkinson's			Have you been overseas in the last month?		
MOBILITY, FITNESS & WELL-BEING			In the last 10 days, have you had any respiratory infection (cold, sore throat, runny nose, sinusitis, cough, flu) or gastroenteritis (vomiting, diarrhoea)?		
Do you use a mobility aid? e.g., a walking stick					
Weight: _____ kg Height: _____ cm					
Have you had any falls in the last 12 months?					

I acknowledge I must not drive/operate machinery/sign legally binding documents within 24 hours of my anaesthetic. I acknowledge I must have a responsible adult stay with me on the day of my procedure and overnight.

Acknowledgment that the patient/representative has filled in this form:

Patient name: _____ Sign: _____ Date: _____

Office use only	Pre-Admission completed by: Name: _____ Sign: _____ Date: _____
Pick up & Carer overnight	Notes/Actions:
24 hrs rest after anaesthetic – no work/ drive/ exercise etc	
Bowel prep instructions and risk informed consent	
Sign: _____ Date: _____	Approved for admission YES / NO PAC required YES / NO

PATIENT REGISTRATION

You have the rights to expect quality, courteous, safe and efficient medical services from the staff of the centre; have clear explanation of your procedures; have the choice of doctors who are accredited with the centre; ask for referral for a second medical opinion; refuse the presence of any health workers not directly involved in your care; ask your doctor and hospital of the expected treatment costs; refuse to have the procedure; have your personal details kept strictly confidential according to the 'Privacy Law'; expect the staff to respect your beliefs, ethnic, cultural and religious practices; and comment on, or complain about, the services you received in the centre.

The Centre expects its patients, their relatives and friends to treat the staff of the centre, other patients, their relatives and friends with courtesy and consideration.

Title:					Given Name:					Surname:									
Address:					Suburb:					Postcode:									
Phone No.:					Date of Birth (DD/MM/YYYY):					Marital Status:									
Email:					Country of Birth:														
Are you [is the person] of Aboriginal or Torres Strait Islander origin?																			
No			Yes, Aboriginal			Yes, Torres Strait Islander			Yes, both Aboriginal and Torres Strait Islander			Decline to answer							
Medicare No.:										Reference No.:			Expiry Date:						
*please advise staff if your Medicare card is reciprocal as it will not cover for this procedure																			
Private Hosp Insurance Fund & Membership No.:										Ambulance Cover: Yes					No				
										* In the unforeseen event that an ambulance is required, please note that it will be at the patient's expense.									
Escort Contact Details (Person taking you home)																			
Name:					Relationship to you:					Contact Number:									
Emergency Contact Details																			
Same as above? Yes No If not, please fill below:																			
Name:					Relationship to you:					Contact Number:									
Power of Attorney (A legal document to appoint someone to make decisions on your behalf)																			
Do you have a Power of Attorney? No Yes If yes, please fill in:																			
Name:					Relationship to you:					Contact Number:									

Note: In accordance with The Privacy Act 1988, the Privacy Amendment (Enhancing Privacy Protection) Act 2012, and Victorian Privacy Principles, the management of The Glen Endoscopy Centre would like to inform you that we gather information from you, when you elect to be a patient of the centre, in order to enable us to provide efficient, safe and effective quality health service to you. Some of the information that we asked from you are needed by government departments which require us to submit information to them as we are registered with the health department as Day Hospital. The information that we gather may be passed on to other health care providers such as pathologists in order to provide the required services for you.

I, _____ give consent to the management of The Glen Endoscopy Centre to provide information regarding myself to health workers, government and statutory bodies in order to provide efficient, Safe and effective qualify health services to myself and to satisfy government and statutory laws and regulations.

I acknowledge that I have reviewed the information on patient rights provided above and staff were available to answer my questions

Signed _____ dated _____